UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

REQUEST FOR EPINEPHRINE EMERGENCY KIT
For Non-Traditional Clients

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX THIS COMPLETED FORM TO (801) 536-0477 or CALL (801) 538-6155, option 3, option 3, option 2 for TELEPHONE PA

CRITERIA FOR EPINEPHRINE EMERGENCY KIT:

Patient is at risk for an anaphylactic reaction.

NOTES:

This form is for Non-Traditional clients (blue card) only. Traditional clients (purple card) may receive this medication without a Prior Authorization.

AUTHORIZATION:

1 year.

RE-AUTHORIZATION:

Telephone call from the physician's office or pharmacy to (801) 538-6155, option 3, 3, 2.

8/4/10

http://health.utah.gov/medicaid/pharmacy